

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-022753

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 1726

FILED JUN 11 1963

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		c. CITY OR TOWN Charlack Village	
Length of stay in 1b D.O.A.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Co. Hosp.		d. STREET ADDRESS (If outside, give location) 2758 Walton Road	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last SCHAEFFER		4. DATE OF DEATH Month May Day 27 , Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-10-16
9. AGE (last birthday) 46		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Prop.		10b. KIND OF BUSINESS OR INDUSTRY St. Louis, Mo.	
11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME William J. Schaeffer		13b. MOTHER'S MAIDEN NAME Corine Schroeder	
14. NAME OF HUSBAND OR WIFE Late Ava Schaeffer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) From 12/23/40 to 6/14/41	
16. SOCIAL SECURITY NO. Corine Schaeffer 2500 Goodole		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) First shot wife and then himself	
20c. TIME OF INJURY Hour 11:10 a.m. Month 5 , Day 27 , Year 1963		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) bedroom of apt	
20e. CITY, TOWN, OR LOCATION Charlack Village		20f. COUNTY St. Louis	
20g. STATE Missouri		20h. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Raymond H. Hurd Coroner Clayton, Missouri	
22b. ADDRESS St. Louis County Mo.		22c. DATE SIGNED 6/4/63	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Entombment		23b. DATE 5/31/63	
23c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum		23d. LOCATION (City, town, or county) St. Louis County Mo.	
24. FUNERAL DIRECTOR Kriegshauser West 9450 Olive St. Road		25. DATE RECD. BY LOCAL REG. 5-29-63	
26. REGISTRAR'S SIGNATURE J. H. Murphy M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

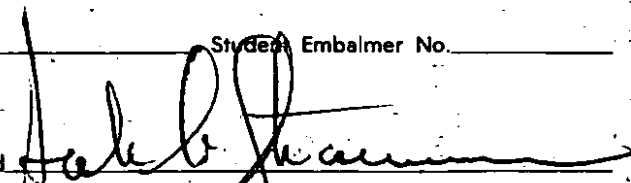
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4533

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.